Trends in International Funding for Malaria Control

August 2005

Prepared for the Roll Back Malaria Partnership

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
DAC	Development Co-operation (part of OECD)
DFID	Department for International Development (DFID)
ECHO	Humanitarian Aid Office of the European Union
EDCTP	European Developing Countries Clinical Trials Programme
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight Aids, TB and Malaria
HIV	Human Immunodeficiency Virus
HLF	High Level Forum
IHSD	Institute for Health Sector Development
MAP	(World Bank) Multi-sectoral AIDS Program
MDGs	Millennium Development Goals
MIM	Multilateral Initiative on Malaria
MMV	Medicines for Malaria Venture
n/a	Not applicable
NGO	Non-Governmental Organization
OECD	Organization for Economic Co-operation and Development
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
R&D	Research and Development
SWAp	Sector Wide Approach
TB	Tuberculosis
TDR	Special Programme on Research and Training in Tropical Diseases
UK	United Kingdom
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization
Y/N	Yes/No

Executive Summary

Study Objectives

The Roll Back Malaria (RBM) Partnership, a coalition of hundreds of partners, is concerned about the level of resources available to support malaria control. It commissioned this study to review external resource flows earmarked for malaria and to explore the attitudes of key development agencies to supporting malaria. This work is intended to feed into efforts to mobilize resources.

Study Methods

The study solicited data from bilateral and multilateral agencies through a questionnaire and follow-up communications. Of the 30 agencies surveyed, 17 responded with varying degrees of completed information, while 5 said the questions were not applicable because they provided no funding specifically for malaria. This gave a response rate of 22/30 (73%). Repeated efforts were made to gather data from other respondents and the period for responses was extended to achieve this rate. The respondents were asked to provide information on their commitments to malaria activities for the years 1999 to 2003 and pledged commitments for 2004, as well as information on funding priorities and trends. Data from the Global Fund to Fight AIDS, TB and Malaria (GFATM) supplemented the data collected through the survey.

Major Findings and Conclusions

Levels and channels of funding

- International funding available for malaria increased over the period 1999 to 2004, with a dramatic rise in 2001 as the Global Fund appeared in the picture. The Global Fund made a vast and sudden difference.

- GFATM funding was generally additional to other malaria funding at least until 2003, as the amount allocated via other sources did not decline. The total amount of non-GFATM funding was broadly stable from 2002-4.

- With the exception of Eastern Europe / Central Asia, spending generally grew (albeit unevenly) in all regions between 1999 and 2004. The fastest growth was in sub-Saharan Africa, by a very considerable margin. Since 2001, Sub-Saharan Africa has received more than 75% of funds.

- Given the growing importance of GFATM as a funding source, the uncertainty over its future level of funding brings considerable uncertainty to future malaria funding. The RBM Partnership needs to monitor global malaria spending over time.

Prioritization by development agencies

- Almost two-thirds of the development agencies that responded to the survey identified malaria as a priority - either specifically, or as part of wider disease control or poverty alleviation work. For some, their interest in malaria related to its importance in poverty reduction and contributing to the MDGs. Malaria as a priority did not necessarily mean high funding for malaria-specific activities – some agencies concentrated on more general types of funding.

- Some development agencies requested better communication about malaria – emphasising the cost-effective interventions; positioning malaria within broader health systems development; and explaining the links between Roll Back Malaria, GFATM and the MDGs.

- Despite the considerable growth in funding for malaria, it can still be argued that it is under-funded relative to HIV/AIDS, given the cost-effectiveness of malaria interventions.

Integrated funding – its implications for malaria

- The survey only looked at funding that agencies could identify as allocated for malaria, plus a share of GFATM funding. Clearly it could not identify funding that is not earmarked for malaria - for example funding that is provided as budget support to the national Finance Ministry, or funding for health sector programmes, part of which may be used for malaria services. As the use of budget support and sector funding rises, it is becoming more difficult to obtain comprehensive information on total external funding for malaria activities through a survey of development agencies. Analysis at country level could look at the picture in terms of funding reaching malaria–related services, possibly for a sample of tracker countries.

- The malaria community needs to understand how to work most effectively within an environment where substantial aid flows are linked to PRSPs with budget support or broader health plans and not earmarked for specific diseases (or even to health). Roll Back Malaria partners may want to explore how to promote such an understanding.

Research and development

- A modest proportion (less than 2%) of the funding was earmarked for research and development. From 2000-4 R&D funding was broadly static – it did not increase in line with the overall increase in malaria funding. This is an area where analysis of funding flows can (and should) be carried out at the global level and analysed to provide a picture of funding trends.

1. Introduction

The Roll Back Malaria (RBM) Partnership is an international coalition with hundreds of partners. It was launched in 1998 by WHO, UNICEF, UNDP and the World Bank to provide a co-ordinated international approach to malaria control and to accelerate social and political action to stop the unnecessary spread of malaria. (Malaria kills more than a million people each year, most of them children.) The Partnership works towards achieving internationally agreed malaria control objectives and has a goal to halve the burden of malaria by 2010.

The *World Malaria Report 2005* states:

> "The estimated cost to support the minimum set of malaria interventions required to reach the 2010 Abuja targets and the Millennium Development Goals for malaria by 2015 for 82 countries with the highest burden of malaria is around US$3.2 billion per year (US$1.9 billion for African countries and US$1.2 for the others)."[1]

This need for increased resources for malaria is occurring at a time of dramatic change in overall development funding patterns. More multilateral and bilateral aid money is going to general budget support or to fund Sector-wide Approaches (SWAps). In these forms of financing, aid money is not specifically earmarked for a particular area such as malaria. At the same time, many new global health initiatives have started – of particular relevance to malaria is the Global Fund to Fight AIDS, TB and Malaria (GFATM). These global initiatives bring new opportunities and challenges, but also increased uncertainty about likely levels of funding for malaria in the future.

To address resource requirements in a systematic manner, the RBM Partnership needs to quantify the current resource levels for malaria and to understand the decision-making processes that determine what resources are made available by various organizations. To this end, a survey was commissioned to obtain data on recent and projected expenditure on malaria for the period 1999-2004. The survey, undertaken by the HLSP Institute (formerly the Institute for Health Sector Development, IHSD), aimed to:

- quantify the international resources currently available for malaria funding
- present an overview of recent funding patterns and identify trends
- outline some of the factors that may explain these trends by reviewing how individual organizations decide on their funding for malaria

It was recognized that the study would only be able to identify funding that the agencies themselves earmarked for malaria activities, and that this would not capture all the international funding eventually used for malaria at country level.

This report draws on the findings from the survey and gives overall estimates of international funding allocated for malaria control for 1999 to 2004. The work reported here is part of a joint survey of funding for malaria and TB. A similar report has been written about TB funding.[2]

[1] WHO/UNICEF. *World Malaria Report 2005*. Section 3, "Global Financing, Commodities and Service Delivery". WHO/HTM/MAL2005.1101. http://rbm.who.int/wmr2005/html/3-1.htm
[2] HLSP Institute (June 2005). *Trends in international funding for TB control.* Stop TB Partnership.

2. Methods

2.1 The questionnaire and survey

Consultants, in liaison with RBM, developed a questionnaire for development agencies. (See Annex A for the full questionnaire.) The questionnaire was sent to any major development organization that had provided in-kind, logistical and/or financial support to malaria initiatives since 1999, either directly or indirectly. An explanatory letter accompanied the questionnaire – it was signed by

- the Chairperson of the Resource Mobilisation Task Force, Stop TB Partnership and Chief of Infectious Diseases and Environmental Health USAID (Dr Irene Koek)
- the Co-ordinator, Global Partnerships for Communicable Diseases - Human Development Network - World Bank and Chairperson of the RBM Working Group on Financing and Resources (Dr Olusoji Adeyi).

30 organizations were sent the questionnaire in July 2004. This included 17 bilateral agencies and 6 development banks. The surveyed organizations were asked to provide detailed information on their financial contributions to malaria for 1999-2003 and pledged contributions for 2004.

The questionnaire also included a series of questions about the agency's objectives in supporting malaria and its priorities for funding. Further questions sought to identify factors that might motivate larger contributions for malaria.

Of the 30 organizations which were sent questionnaires:

- 17 responded with varying degrees of completed information on malaria
- 5 replied that the survey was not applicable to their organization – i.e. they did not directly fund malaria activities
- A number repeatedly promised to fill in the questionnaire, but no reply was received

The response rate was thus 73% (22/30). None of the multilateral development banks submitted substantive financial data.

The questionnaires were sent out in July 2004, and replies accepted until early November that year. There were repeated follow-up contacts to remind organizations to fill in the questionnaire. Given the support for the questionnaire from RBM and the seniority of the signatories of the accompanying letter – plus the work on reminding people and the policy to accept data in any format – the response rate was somewhat low.

As well as the response rate, the incompleteness of many responses posed a problem - many respondents (9/17) were unable to provide financial data for the whole period requested.

Given the above, the authors conclude that even well-planned and supported questionnaires to development agencies meet with many practical problems when asking about disease-specific funding.

Six organizations requested that the data they provided be used in an aggregated, non-attributable format. The request for confidentiality is respected in this report.

2.2 Additional data source – GFATM

The responses to the survey were supplemented by published information about GFATM funds.[3] This was necessary because, of the major donors to GFATM, only Canada, UK and USA provided financial information to this survey. In order to make the estimates more complete, a share of all other contributions to the Global Fund was therefore included. The share used is 31% of GFATM contributions from other donors, reflecting the overall percentage of GFATM funding which was committed to malaria. In order to analyze how funds for malaria were allocated amongst regions, data was obtained on disbursements by GFATM to malaria projects by country[4].

Note that two different types of figure are used about GFATM – overall funds available and actual disbursement to countries. The former figure is larger because of delays in disbursement. Total budgets for malaria programmes approved by GFATM were some $1.8 billion by July 2005 - of this only $312 million (17%) had been disbursed[5]. Then there is a second delay before disbursed funds are actually spent.

Incomplete disbursement of funds available is not unique to GFATM – indeed it could occur at some stage for most of the sources or uses of money included here. However, the distinction between available funds and disbursement is only made for GFATM in this report. The reasons are:

- The magnitude of the issue for the Global Fund – it is the major international channel for resources for malaria and had a low disbursement rate in the period being studied.
- Data availability – respondents to the questionnaire gave figures on final expenditure, with the blanket assumption that this money had been disbursed. (For 2004, the figures are projections of planned spending.)

[3] Data from www.theglobalfund.org, December 2004. The *World Malaria Report 2005* also used the figure of 31% of GFATM funding for malaria.
[4] Data from www.theglobalfund.org, December 2004.
[5] Data from www.theglobalfund.org, July 2005.

3. Findings - Trends in Malaria Funding

3.1 Overall financial contributions to malaria control activities

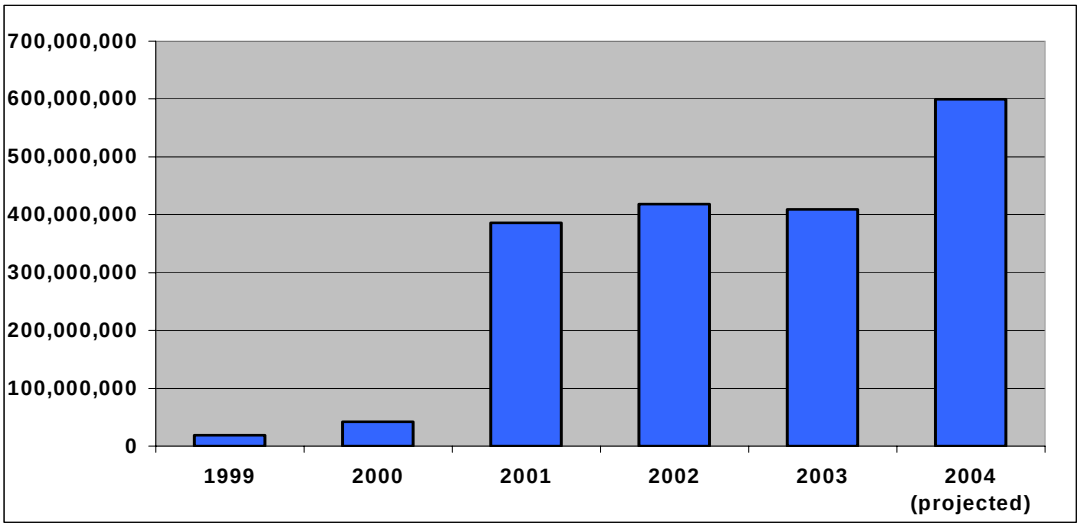
Table 1 and Figure 1 show estimated total financial contributions to malaria identified through the 2004 survey and GFATM. This was money available for malaria, but which had not necessarily been disbursed to countries.

Table 1: Estimated contributions to malaria control activities by development agencies

Fiscal year	Total Contributions (US$)	% of total	No. of Respondents
1999	19,129,701	1%	4
2000	42,287,888	2%	8
2001	386,285,841	21%	8
2002	418,551,580	22%	8
2003	409,595,904	22%	8
2004 (projected)	599,416,847	32%	7
Total Overall	**1,875,267,762**	**100%**	

Sources: 2004 survey initiated by RBM; GFATM (31% of commitments)

Figure 1: Estimated contributions to malaria control activities by development agencies (US$)



Based on Table 1

There was an increase in international funding available for malaria over the period 1999 to 2004, with a dramatic rise in 2001. The data needs to be interpreted with some care, however, as:

- The figures understate the true picture because of missing responses from a few key agencies to the 2004 survey.
- The number of agencies included in the analysis is not constant from year to year. Most of this is due to a real change in the number of agencies involved in malaria funding, but there are also gaps in the responses. The huge increase in 2001, however, was not an artefact – this was because of the start of GFATM.

- As explained above, the sum for GFATM reflects available funding, rather than in-country spending.

- Some agencies pointed out that there may be an under-estimate of funding for malaria as part of emergency relief operations. Such funding is often not broken down into disease-specific categories and may be provided through a different part of a development agency.

3.2 Recipients of financial contributions

The 2004 survey asked agencies to break down their funding according to the type of recipient, using the following categories:

- **Country level** – malaria programs of national governments

- **Projects and NGO** – specific malaria projects and NGOs involved in malaria programs

- **Research and development (R&D)** – applied R&D in malaria control

- **Global Activities** – i.e. contributions to GFATM.

- **Other Activities** – any other financial contributions which do not fit in the above categories. This includes funds for Roll Back Malaria, the Malaria Consortium and the Special Programme on Research and Training in Tropical Diseases (TDR).

Table 2 and Figure 2 show the breakdown of development agency funding by recipient type. The sources are the same as for Table 1. For GFATM, it is again important to note that the figures used show the level of funding available to GFATM, not disbursements.

The following points can be made about Table 2:

- The Global Fund has made a vast and sudden difference to international flows of money for malaria.

- The data suggest that GFATM funding was generally additional to other malaria funding at least to 2003, as the amount allocated via other sources did not decline. The exception to this is the decline in funding for “other” after 2002. The total amount of non-GFATM funding was broadly stable from 2002-4.

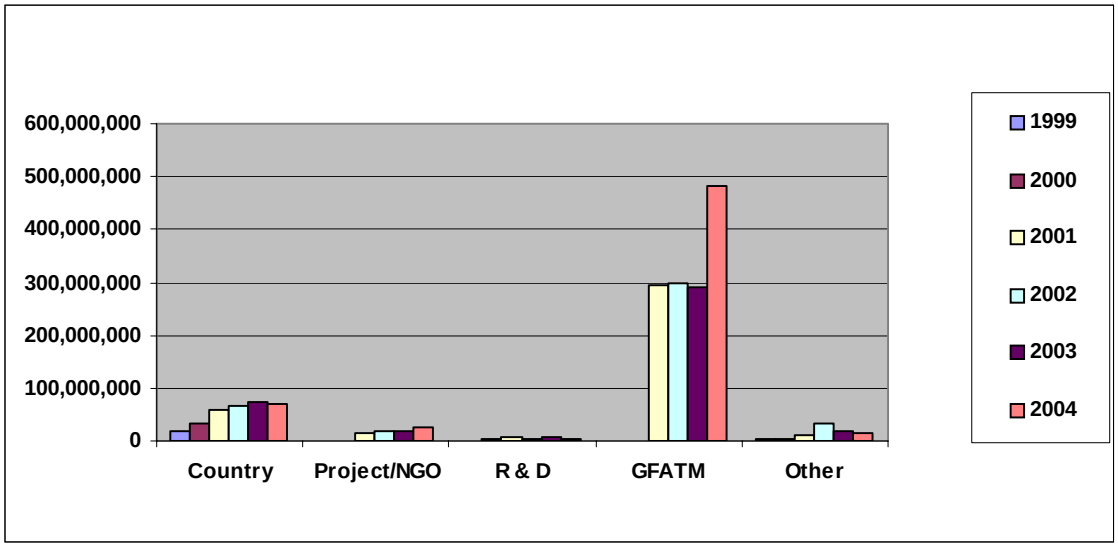
- A modest proportion (less than 2%) of the funding was earmarked for research and development. Foundations tended to fund R&D directly and specifically; bilaterals did not. From 2000-4 R&D funding was broadly static – it did not increase in line with the overall increase in malaria funding. This is an area where analysis of funding flows can (and should) be carried out centrally and analysed to provide a picture of funding trends.

Table 2: Recipient of contributions from development agencies, 1999-2004, US$

Recipient	Fiscal Year 1999	2000	2001	2002	2003	2004	Total
Country	17,096,016	32,178,850	59,076,544	66,026,930	75,258,761	71,673,994	**321,311,095**
Project/NGO	0	0	14,780,123	18,855,546	18,205,065	25,583,001	**77,423,735**
R & D	0	5,447,566	6,206,175	4,440,407	6,643,226	4,731,608	**27,468,981**
GFATM	0	0	293,725,000	296,453,000	289,850,000	484,003,000	**1,364,031,000**
Other	2,033,685	4,661,472	12,497,998	32,775,697	19,638,853	13,425,244	**85,032,950**
Total Contributions	**19,129,701**	**42,287,888**	**386,285,841**	**418,551,580**	**409,595,904**	**599,416,847**	**1,875,267,762**

Sources: 2004 survey initiated by RBM; GFATM.

Figure 2: Recipients of contributions from development agencies (US $), 1999-2004



Based on Table 2

3.3 Financial contributions to malaria control activities by Region

The 2004 survey asked agencies to list their contributions to individual countries. For data analysis purposes, these were grouped by region. Table 3 and Figure 3 show spending disaggregated into five regions. The classification of countries by region is shown in Annex B.

The figures from GFATM are actual disbursements to malaria projects in 2003 and 2004[6]. Note that this is different from the information on GFATM's overall available funding used in Tables 1 and 2.

Table 3 shows:

[6] The figures for GFATM spend by region reflect disbursements made from the Fund to countries for malaria grants, based on data in GFATM Progress Reports for end 2003 and 2004. This is different from the commitments to GFATM from development agencies in Table 1, which represented funds available for malaria. It will still overstate actual spending on malaria control in country, as not all the disbursements will be spent in the year.

- With the exception of Eastern Europe / Central Asia, spending generally grew (albeit unevenly) in all regions between 1999 and 2004. The fastest growth was in sub-Saharan Africa, by a very considerable margin.

- Since 2001, Sub-Saharan Africa has received more than 75% of funds.

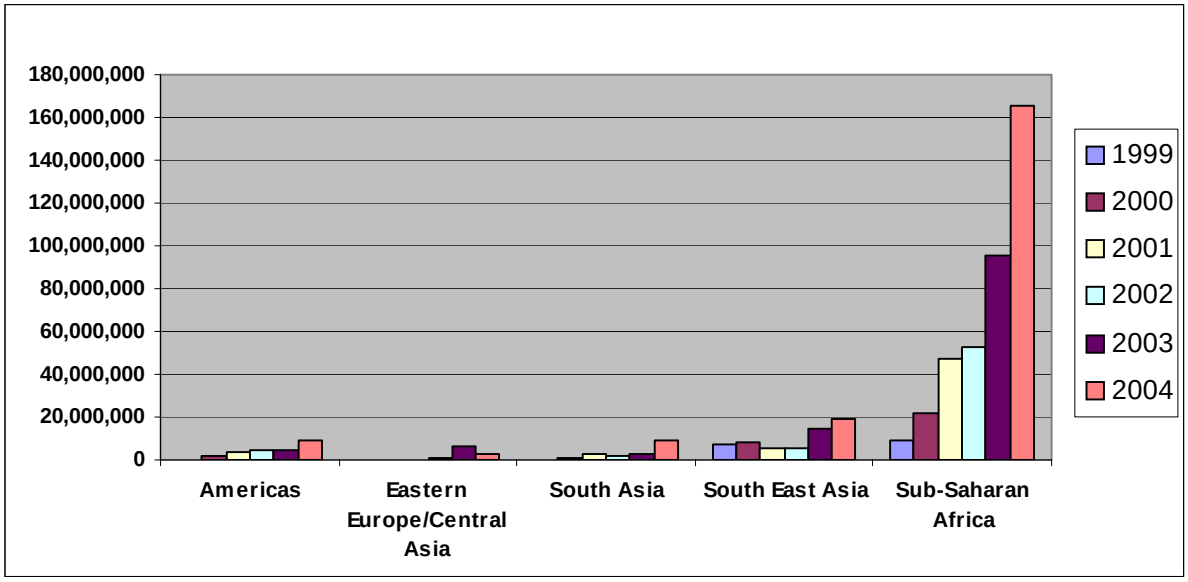
- Funding to regions increased hugely in 2003 and again in 2004. This reflects funding decisions made by the Global Fund. Again Eastern Europe / Central Asia is atypical, with a one-year peak in 2003.

Table 3: Funding by region (US $)

Recipient Region	Fiscal Year 1999		2000		2001		2002		2003		2004		Totals
Americas	382,500	2%	1,660,200	5%	3,580,900	6%	4,533,200	7%	4,209,601	3%	9,443,892	5%	**23,810,293**
Eastern Europe/Central Asia	0	0%	195,000	1%	0	0%	961,000	1%	6,674,195	5%	2,376,417	1%	**10,206,612**
South Asia	159,800	1%	716,000	2%	2,937,039	5%	2,254,041	3%	2,764,337	2%	9,120,588	4%	**17,951,805**
South East Asia	7,188,640	42%	7,858,399	24%	5,003,220	8%	5,210,568	8%	14,449,272	12%	19,367,190	9%	**59,077,290**
Sub-Saharan Africa	9,365,076	55%	21,749,251	68%	47,555,385	80%	53,068,120	80%	95,335,266	77%	165,451,173	80%	**392,524,275**
Total	**17,096,016**		**32,178,850**		**59,076,544**		**66,026,930**		**123,432,671**		**205,759,260**		**503,570,276**

Sources: 2004 survey initiated by RBM; GFATM – actual disbursements

Figure 3: Funding by region (US$)



Based on Table 3

4. Qualitative Information from the Questionnaires

4.1 Agency Priorities

The survey of bilateral and multilateral agencies asked:

"Are the following specifically identified as priorities for funding by your organization?

- Health Y/N
- Communicable diseases Y/N
- TB Y/N
- HIV Y/N
- Malaria Y/N
- Poverty-alleviation programmes Y/N
- R&D for diseases such as TB and Malaria Y/N"

The following proportions of respondents replied "yes" (i.e. it *is* a specifically identified priority):

Priority	**% of respondents**
Health	100%
Communicable diseases	71%
TB	57%
HIV	86%
Malaria	64%
Poverty-alleviation programmes	93%
R&D for diseases such as TB and Malaria	36%

The agencies that did not identify malaria as a priority per se generally said that where their emphasis is on primary health care, communicable diseases are a strong priority. They also stated that malaria may be an important component of poverty alleviation programmes. In general, the multilateral development banks did not separately identify malaria as a priority.

Four out of 22 respondents stated that their organization had a dedicated office or personnel dealing specifically with malaria. Of the respondents who commented on this, it was noted that malaria often cuts across various initiatives relating to global health, AIDS and reproductive/child health.

4.2 Reasons for Funding Malaria

The survey questionnaire asked:

> "This survey aims to identify trends in TB and malaria funding and the reasons behind the trends. What factors determine the funding decisions taken by your organization in relation to TB and malaria, which the questionnaire has not already asked about? *(Examples could be political changes, or a shift in emphasis to other diseases.*)

The factors that determine malaria funding decisions can be classified as follows:

The impact on poverty alleviation – 13 of the 14 respondents to this question indicated poverty alleviation as a priority. 3 agencies specified that where poor and marginalized populations are particularly affected by malaria, they were prepared to finance malaria activities.

International commitments – the Millennium Development Goals (MDGs) include international targets for malaria. For some agencies, their commitment to the MDGs justified their funding for malaria.

Proportionality with responses to other diseases - comparisons were made with HIV/AIDS in particular. Some respondents mentioned that the priority afforded to HIV reduced funding for other diseases – including malaria.

The Global Fund - GFATM is regarded as of growing importance and is recognised as a major channel for international malaria money.

Agreed country strategy - requests for assistance for malaria may be specifically included in agreed country strategies for funding from development agencies.

4.3 Research and Development of new tools

Agencies were asked:

> "Would your organization consider funding for development of new tools for malaria diagnosis, new drugs and vaccines? If not, what evidence and/or documentation would be needed to open a discussion on this issue?"

Various agencies support malaria R&D initiatives through a range of mechanisms including:

- CDC (the Centers for Disease Control and Prevention)
- Special Programme on Research and Training in Tropical Diseases (TDR)
- European and Developing Countries Clinical Trials Partnership (EDCTP)
- Medicines for Malaria Venture (MMV)
- Multilateral Initiative on Malaria (MIM).

USAID funds research for malaria diagnostics and new drugs; the Islamic Development Bank launched its own dedicated Vaccines Production Program in 1999.

In response to the second question, those agencies which responded may be prepared to finance new tools for malaria control (including drugs, diagnostics and vaccines) where evidence exists of:

- favourable cost / benefit ratios
- cost control and quality assurance of R&D processes
- some likelihood of future self-reliance in vaccine production.

4.4 Mobilizing funds for malaria

The 2004 survey questionnaire asked:

> "Malaria funding is often integrated with general health systems funding. Given this, how might the RBM partnership effectively lobby for a higher priority (and more funding) for malaria?"

Responses followed the following themes:

Greater advocacy about the importance of the malaria programme within general health system strengthening. Links need to be made between broader health systems development and specific requirements for malaria. The importance of funding for malaria needs to be emphasised – highly cost-effective malaria interventions are often under-funded.

Aid harmonization of international and regional initiatives. Many respondents wanted RBM and the Global Fund to articulate more clearly how they could collaborate to make efficient use of the funds available. There was a request for more information on how GFATM funding and MDG commitments could be incorporated into mainstream activities at the national level.

Collaboration with local bodies – the majority of respondents highlighted the importance of working closely with governments and development agency representatives at country level, along with the recognition that decision-making often rests with key officials within the Ministries of Health and/or Finance.

The questionnaire then asked:

> "Would your organization consider funding "mini-baskets" of priority disease interventions, or of funding specific government budgets for malaria? Why (not)?"

This question received a mixed response. Four respondents, replied **no**, as they considered that direct support for malaria, or initiatives such as GFATM, were sufficient.

However, there were two categorical **yes** answers – these respondents already had a track record of support to basket funding.

The remaining responses were **conditional yes**. Basket funding could be considered but would depend heavily on context; would be at the recipient's request; and would have to be an integrated approach which would fit with overall sector plans.

5. The Growing Importance of Global Health Partnerships

The sections above have demonstrated the importance of the Global Fund as a major player in international malaria funding. This section briefly looks at wider work on Global Health Partnerships to raise issues of relevance to this paper – it draws heavily on Pearson (2004)[7] Five specific issues are identified:

a) The Global Health Partnerships appear likely to deliver **significant additional funding** for communicable diseases, including malaria.

b) There is currently no accurate **methodology for tracking** expenditure on communicable diseases.

c) In a very general sense, GFATM funding for malaria is **well targeted**.

d) The availability of substantial amounts of new Global Health Partnership funding – particularly through GFATM – raises key issues about **sustainability.**

e) The **uncertainty** of Global Health Partnership funding causes problems.

a) Significant additional funding

Pearson concludes that the Global Health Partnerships appear likely to deliver significant additional funding for communicable diseases[8] - the malaria data in this report support this conclusion.

This increase in international funding for communicable diseases is occurring against a backdrop of strong growth in development assistance for health in general. This growth has been sustained over the last three decades and has seen significant increases in real development agency spending on health and population of the order of 3% per annum since 1975. Development agency support for health has increased rapidly as a proportion of overall development assistance, as the latter stagnated in the 1990s and is only now beginning to increase again. The fact that overall development assistance flows are also increasing again – by 7% between 2001 and 2002 and a further 4% between 2002 and 2003 – bodes well for the future funding of communicable diseases.

Although there currently appears to be additional, new money for malaria, there is no room for complacency. It is important to regularly monitor what is happening in terms of actual spending within countries – information from agencies can mask problems with disbursement and absorptive capacity.

b) Methodology for tracking expenditure

This report describes the many methodological problems encountered with a survey of development agencies – including incomplete responses and the fact that many agencies provide general budget support which does not earmark funds for particular activities such as malaria control. As malaria funding changes in its nature, new expenditure tracking tools need to be developed.[9] One option is to

[7] This section draws heavily on Caines, K et al (2004). *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre. http://www.dfidhealthrc.org/shared/know_the/publications.html#ghp This review of consists of a synthesis report and 7 individual papers. Of particular relevance to this report is Pearson, M. *Study Paper 2: Economic and Financial Aspects of the Global Health Partnership*.

[8] Pearson, M. (2004) *Economic and Financial Aspects of the Global Health Partnerships*. DFID Health Resource Centre. Pages 4-5.

[9] In general, DAC data from the OECD are the best means of tracking development assistance flows, but suffer from a number of significant weaknesses. (I.e. the data from the Development Co-operation Directorate of the Organization for Economic Co-operation and Development.)

invest in improved National Health Accounts, and to seek stronger, more disaggregated data about spending on individual diseases.

The Global Health Resource Tracking Working Group, convened by the Center for Global Development, is taking forward work on improved expenditure tracking, focussing on support to national governments. This topic has been identified as a priority by the High Level Forum (HLF) on the Health Millennium Development Goals[10] - the conclusions of the Working Group will be considered by the HLF in November 2005 meeting.

c) GFATM funding for malaria is well targeted

In his review of the economic aspects of Global Health Partnerships, Pearson argues that, in broad terms, GFATM funding for malaria is well-targeted. A number of justifications are given for this:

- Malaria causes a major burden of **ill health**.

- There are potentially highly **cost-effective interventions** related to malaria. (The extent to which the potential is translated into reality depends on a number of factors, including health system capacity.) Pearson puts forward the argument that the cost-effectiveness of some malaria interventions means that malaria is under-funded compared with HIV/AIDS:

  > "Recent analysis of spending on HIV/AIDS control suggests that spending in this area may represent around half of total aid flows for health. Yet HIV/AIDS only accounts for around 5% of the global burden of disease and only in Africa does it exceed 10% (up to 27% in high adult high child mortality countries and just under 20% overall). Malaria accounts for around half of the HIV/AIDS burden of ill health yet development assistance for malaria is only around one-twenty fifth of that provided for HIV/AIDS control and this despite the fact that investments in malaria are arguably likelier, on average, to be more cost effective and more pro poor than HIV/AIDS interventions."[11]

- Allocations by Global Health Partnerships appear to be more focused on poorer countries than recent trends in overall development agency assistance for health and population. Pearson uses allocations to Africa (see next bullet) and national income status as crude measures of whether allocations were "**pro-poor**". He concludes that GFATM's grants for malaria and TB are more pro-poor than recent allocations for infectious diseases from development assistance in general. This is true even though GFATM provides some support to higher-income countries (though this is mostly not for malaria).[12]

- The question of equity was addressed by asking whether **Africa** is receiving its "fair" share of funding from the Global Health Partnerships. In other words, does Africa receive a proportion of the funds similar to its proportion of the global burden of disease? Table 4 addresses this issue. For malaria, Africa is almost receiving its fair share. 81.9% of the global malaria burden is in Africa, which received 78.4% of GFATM's malaria allocations.[13]

It is interesting to compare Pearson's work with the findings of this report. Table 3 shows that 78% of funds went to Africa – the same as the global burden of malaria.

[10] See for example, High-level Forum on the Health MDGs (2004). *Tracking resources for global health: progress toward a policy-responsive system. http://www.hlfhealthmdgs.org/Documents/TrackingResources-Final.pdf*
[11] Pearson, *Op. cit.* Page 16.
[12] Pearson, *Op. cit.* Page 15.
[13] Pearson, *Op. cit.* Page 16.

Table 4 Africa: Burden of disease and Global Health Partnership Funding

	% Burden of Disease in Africa	% Funding from Relevant Global Health Partnership going to Africa
Infectious and parasitic diseases	54.6	n/a
Tuberculosis	26.2	31.6% (GFATM)
HIV/AIDS	82.9	61.0% (GFATM) and 91% of HIV-TB combined funding
Childhood diseases	47.1	65.0% (GAVI – Global Alliance for Vaccines and Immunization)
Malaria	81.9	78.4% (GFATM)
Poliomyelitis	16.2	29.3% (Global Polio Eradication Initiative)
Meningitis	36.8	See GAVI
Hepatitis	42.0	See GAVI
Tropical diseases	54.9	n/a

Source: Pearson (2004)

d) Sustainability and national macro-economic stability

The availability of substantial amounts of new Global Health Partnership funding – particularly through GFATM – raises key issues about sustainability. Although money from the Global Health Partnerships is relatively minor in terms of overall public funding for health, it does significantly add to existing resource flows in a number of countries. In 13 countries, the Partnerships account for at least a 50% increase in health spending, and in 3 of these it exceeds 100% (Ethiopia, Liberia and Malawi). The issue is more extreme when funding from other health initiatives such as the (World Bank) Multi-sectoral AIDS Program and the (US) President's Emergency Plan for AIDS Relief (MAP and PEPFAR) are included. Many low-income countries will have great difficulty in funding ongoing costs if Partnerships' funding for current activities ends as planned after a 5-year period. In this context of sustainability, the period 2008 to 2010 is crucial, as this is when initial GAVI and GFATM commitments end.[14] This is clearly an issue for the Roll Back Malaria Partnership to monitor closely.

e) Uncertainty

The rapid rise to prominence of the Global Health Partnerships, notably the Global Fund, offered many opportunities for new work in malaria. However it also produced a number of uncertainties:

- For individual countries, there has been uncertainty about if and when proposals will be approved and actually funded. In some cases (e.g. Ghana), where Government has identified Partnership-funded programs as part of its national strategies, distortions were created by non-approval of GFATM proposals.[15]

- There is uncertainty about future development agency spending plans – they might increase their support to GFATM and reduce their funding to other malaria-specific channels or country health programmes, or they might increase funding to all these funding mechanisms.

- Future levels of funding for GFATM are uncertain. In order to illustrate how this might affect malaria funding, two scenarios were considered - funding levels if GFATM was not replenished beyond existing pledges (the 'low case') and funding levels if GFATM achieved

[14] Pearson, *Op. cit.* Page 13.
[15] Pearson, *Op. cit.* Page 18.

the proposed 'steady state' stabilising at about $3.3 billion per year[16]. The total pledged for 2007 at the time of writing (July 2005) was $772 million. If 31% of this is allocated to malaria, this suggests funding of $239 million for malaria in 2007. For the more optimistic 'steady state' scenario, 31% of the $3.3 billion to be disbursed in 2007 would mean $1.0 billion in international funding for malaria. This is a substantial increase on current levels and about one-third of the $3.2 billion cited by the World Malaria Report (and quoted in the Introduction of this report).

The sustainability of malaria-related activities will crucially depend on decisions by development agencies about GFATM, as well as whether some will continue funding earmarked for malaria.

[16] See November 2004 GFATM Board Paper GF/B9/5, page 4.

6. Conclusions and Recommendations

Conclusions from the data

The data presented in Sections 3 and 4 showed:

- An increase in international funding available for malaria over the period 1999 to 2004, with a dramatic rise in 2001 as the Global Fund appeared in the picture. The Global Fund made a vast and sudden difference.

- GFATM funding was generally additional to other malaria funding at least to 2003, as the amount allocated via other sources did not decline. The total amount of non-GFATM funding was broadly stable from 2002-4.

- A modest proportion (less than 2%) of the funding was earmarked for research and development. From 2000-4 R&D funding was broadly static – it did not increase in line with the overall increase in malaria funding.

- With the exception of Eastern Europe / Central Asia, spending generally grew (albeit unevenly) in all regions between 1999 and 2004. The fastest growth was in sub-Saharan Africa, by a very considerable margin. Since 2001, Sub-Saharan Africa has received more than 75% of funds.

- Almost two-thirds of the development agencies that responded to the survey identified malaria as a priority - either specifically, or as part of wider disease control or poverty alleviation work. For some, their interest in malaria related to its importance in poverty reduction and contributing to the MDGs. Malaria as a priority did not necessarily mean high funding for malaria-specific activities – some agencies concentrated on more general types of funding.

- Some demand for better communication about malaria – emphasising the cost-effective interventions; positioning malaria within broader health systems development; and explaining the links between Roll Back Malaria, GFATM and the MDGs.

Changes in aid modalities make it difficult to identify the extent to which development agencies are funding malaria activities. The move to SWAps and budget support, plus the emergence of GFATM, mean that much development agency support is not earmarked for malaria. Some survey respondents found it impossible to isolate funding for malaria from their funding for health generally or budget support. Other agencies did not respond to the survey at all. Although these issues had been anticipated from the start of the work, and discussed during the development of the approach, the number of respondents was still lower than may have been anticipated. For future assessment of the adequacy of funding for malaria, it is concluded that it would be useful to focus on malaria funding at national level, plus global work on funds for research and development. Even well-planned and well–supported questionnaires to development agencies meet with many practical problems when asking about disease-specific funding.

Recommendations

1. Changing funding modalities have meant that this survey has had a limited response to its questions on malaria-specific funding. Increasingly, development agencies favour general budget support, which sees funding for a pre-agreed program of activities channelled through the recipient government's national treasury, planning, budgeting, accounting and auditing systems. In return for acceptable performance against certain criteria, the recipient government receives funding into

its national consolidated accounts, which may not be earmarked for the health sector, let alone for disease-specific interventions.

In order to have a clearer picture of malaria funding, it is necessary to review what is happening at country level. Possible ways of systematizing this work include:

a. identifying some "tracker" or sentinel countries, where data on actual expenditures on malaria from different sources was regularly analysed. The 2005 *World Malaria Report* includes a sub-section on "Financing for Malaria" in its country-specific data section. This could be related to information on which agencies contributed to budget support in the country – making a link between individual donors and malaria.

b. liaising with work on National Health Accounts and ensuring that malaria-specific information is collected whenever possible.

c. involvement in the work of the Global Health Resource Tracking Working Group, convened by the Center for Global Development.

2. As noted above, the context of international funding for malaria has changed over recent years. General budget support, SWAps and Poverty Reduction Strategies have become increasingly important. It is vital that "malaria people" at national, regional and global level, understand the changing development and aid environment, and know how to operate effectively within it. Work has been done on how other vertical-type programmes can adapt to the new funding environment – for example, UNFPA recently commissioned a report on how to promote Reproductive Health Commodity Security in the context of SWAps, PRSPs and Budget Support.[17] Materials such as this could be adapted for malaria.

3. GFATM has brought in additional funding for malaria. However its future level of funding is unclear. If the Fund is not replenished there will be major implications for the sustainability of malaria control activities. This situation needs to be monitored by RBM partners, including whether the funding for GFATM continues to be additional to other malaria funding. The period 2008 to 2010 is crucial, as this is when initial GFATM commitments end. Monitoring should clearly differentiate between commitments and actual expenditure, as some countries may face problems of absorptive capacity.

4. Development agencies' interest in malaria is closely linked to their wider priorities of poverty reduction and achieving the MDGs. Work on resource mobilization for malaria should emphasize the linkages between malaria and poverty and the relevance of malaria control to the MDGs. There is also a more general need for better communication about malaria – emphasising the cost-effective interventions; positioning malaria within broader health systems development; and explaining the links between Roll Back Malaria, GFATM and the MDGs.

5. Information on funding for malaria-related research and development of new tools should be collected at a central level, and trends monitored (also against those for other key diseases). Recent estimates from the Global Forum for Health Research estimate spending of around $126 million per year for malaria research, compared with $1.4 billion for HIV and $45 million for TB research. [18]

[17] Reproductive Health Commodity Security and Aid Instruments, IHSD, 2004.
[18] Global Forum for Health Research, Monitoring Financial Flows for Health Research, 2004

ANNEXES

Annex A - Questionnaire Sent to Development Agencies

Survey of International Funding for TB and Malaria Control

Two Global Partnerships - Stop TB and Roll Back Malaria (RBM) - have commissioned a survey about international funding trends for TB and malaria. Stop TB has developed a resource mobilization strategy while developing one is an important part of RBM's work, following its re-structuring in 2002. The results of the survey will be invaluable for making a strong case for adequate funding for TB and malaria control. The Institute for Health Sector Development (IHSD) is carrying out the survey.

A response from your organization is very important if complete pictures of international funding for TB and malaria are to be built up. The authors of this questionnaire fully appreciate that for some organizations parts of the questionnaire will be difficult to complete – for example because funds are not disbursed on a disease-specific basis. Table 1 and 2 provide one possible way of presenting the data. However **if you would prefer to present the information in another format, which is more convenient for you, please feel free to do so.** In general, if you have difficulties filling in the questionnaire, please do not hesitate to contact Jackie Martin of IHSD (contacts below) and she will discuss the best way of tackling the problem.

We will follow up many of these questionnaires in writing or by telephone to discuss your answers more fully.

We fully appreciate that some of this data may be confidential. Question 18 gives you the opportunity to have the data used only on an aggregated, non-attributable basis.

We really do appreciate the time you spend on this issue. All respondents will be sent a copy of the completed survey report.

RESPONDENT INFORMATION

1. Organization:

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2. Name of respondent:

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3. Designation within the organization:

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4. Contact details: *(address, telephone, fax, e-mail):*

5(a). Do you have a dedicated unit or office within your organization dealing exclusively with TB activities? *(If so, specify)*

5(b). Do you have a dedicated unit or office within your organization dealing exclusively with malaria activities? *(If so, specify)*

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6. Do you have a dedicated unit or office within your organization dealing only with research? *(If so, specify)*

ALLOCATION OF FUNDING

7. Please complete Table 1 (TB) and Table 2 (malaria) at the end of this questionnaire. This asks about the recipients of your support. *(Examples of recipients are country governments, NGOs, global funds etc. Spaces at the bottom of the table are provided for "other" recipients.)*

8. Some organizations may be unable to identify malaria-specific and TB-specific expenditure as funds may be provided in an aggregated manner or as general budget support. If this applies to your organization, please specify, with estimated expenditure if possible.

9. Are some of the monetary values included in Tables 1and 2 valuations for inputs provided in-kind? If yes, please explain.

10. Are there any contributions your organization provides for TB or malaria which have not been included in Tables 1and 2? *(e.g. in-kind contributions, seconded staff)* **Please specify, including a financial valuation, if possible.**

PRIORITIES FOR FUNDING

11. Are the following specifically identified as priorities for funding by your organization?

- Health Y/N
- Communicable diseases Y/N
- TB Y/N
- HIV Y/N
- Malaria Y/N
- Poverty-alleviation programmes Y/N
- R&D for diseases such as TB and Malaria Y/N

Comments?

12. Does your organization provide funding for emergency relief operations (either directly or through an organization such as ECHO)? If so, is this data included in Tables 1 and 2, or available through another source? What is that source?

FUNDING TRENDS

13 (a). Would your organization consider funding for development of new tools for TB diagnosis, new drugs and vaccine? If not what would the evidence and or documentation be needed to open a discussion on this issue?

13 b). Would your organization consider funding for development of new tools for Malaria diagnosis, new drugs and vaccine?
If not what evidence and or documentation would be needed to open a discussion on this issue?

14. This survey aims to identify trends in TB and malaria funding and the reasons behind the trends. What factors determine the funding decisions taken by your organization in relation to TB and malaria, which the questionnaire has not already asked about? *(Examples could be political changes, or a shift in emphasis to other diseases.*)

THE FOLLOWING QUESTIONS RELATE TO MALARIA ONLY.

15. Malaria funding is often integrated with general health systems funding. Given this, how might the RBM partnership effectively lobby for a higher priority (and more funding) for malaria?

16. Following on from question 15, would your organization consider funding "mini-baskets" of priority disease interventions, or of funding specific government budgets for malaria? Why (not)?

17. If you do not currently directly support malaria, under what conditions might you do so?

18. We would like to use the information you have provided in this questionnaire and attribute it to your organization. However we also respect the potential confidentiality of your information. Please tick here if you only want the information to be used in the report in an aggregated, non-attributable form.

Jackie Martin
For Institute for Health Sector Development
E-mail: TBandMalaria@ihsd.org

Table 1: Breakdown of Spending on TB by Recipient, 1999-2005

If you would prefer to present the information in another format, which is more convenient for you, please feel free to do so.

1. *Please provide details of expenditures by your organization, beginning with the total and then detailing by recipient, on TB activities for each of the years 1999 to 2005. (making clear whether pledged, or disbursed). Where complete information may not yet be available, please estimate.*
2. *State currency units used.*

Year	Currency	1999	2000	2001	2002	2003	2004 *(projected)*	2005 *(projected)*
Total ex-penditure on TB activities								
Country 1 (please name)								
Country 2 (please name)								
Country 3 (please name)								
Country 4 (please name)								
Country 5 (please name)								
NGO 1 (please name)								
NGO 2 (please name)								
NGO 3 (Please name)								
Applied R&D Programmes for TB								

Year	Currency	1999 *	2000 **	2001	2002	2003	2004 *(projected)*	2005 *(projected)*
Global Fund to Fight AIDS, TB & Malaria (GFATM)								
The Global Drug Facility								
New Tools Development								
Other global activities 1 (specify)								
Other global activities 2 (specify)								
Other 1 (specify)								
Other 2 (specify)								
Other 3 (specify)								

*** / ** The Data inserted in Table 1 for 1999 and 2000 has been taken from a former survey. If this data does not reconcile to your records, please make any adjustments necessary.**

Table 2: Breakdown of Spending on Malaria by Recipient, 1999-2005

If you would prefer to present the information in another format, which is more convenient for you, please feel free to do so.

1. *Please provide details of expenditures by your organization, beginning with the total and then detailing by recipient, on Malaria related activities for each of the years 1999 to 2005. (making clear whether pledged, or disbursed). Where complete information may not yet be available, please estimate.*
2. *State currency units used.*

Year	Currency	1999	2000	2001	2002	2003	2004 *(projected)*	2005 *(projected)*
Total ex-penditure on TB activities								
Country 1 (please name)								
Country 2 (please name)								
Country 3 (please name)								
Country 4 (please name)								
Country 5 (please name)								
NGO 1 (please name)								
NGO 2 (please name)								
NGO 3 (Please name)								

Year	Currency	1999	2000	2001	2002	2003	2004 *(projected)*	2005 *(projected)*
Applied R&D Programs for malaria								
Global Fund to Fight AIDS, TB & Malaria (GFATM)								
Malaria Medicine Supply Service								
New Tools Development								
Other global activities 1 (specify)								
Other global activities 2 (specify)								
Other 1 (specify)								
Other 2 (specify)								
Other 3 (specify)								

Annex B - Classification of Countries into regions (used in Table 3)

Americas	Eastern Europe/Central Asia	South Asia	South East Asia	Africa
Brazil	Albania	Bangladesh	Burma	Angola
Bolivia	Armenia	India	Cambodia	Benin
Dominican Rep.	Baltic States[19]	Nepal	East Timor	Botswana
Ecuador	Estonia	Pakistan	Indonesia	Burkina Faso
El Salvador	Georgia		Laos	Burundi
Haiti	Moldova		Philippines	Cameroon
Honduras	Russia		Papua New Guinea	Congo (Democratic Republic)
Nicaragua	Ukraine		Vietnam	Egypt
Mexico				Ethiopia
Panama	Afghanistan			Ghana
Peru	Kazakhstan			Kenya
	Kyrgyzstan			Lesotho
	Tajikistan			Malawi
	Turkmenistan			Morocco
	Uzbekistan			Mozambique
				Namibia
				Nigeria
				Rwanda
				Senegal
				Somalia
				South Africa
				Sudan
				Swaziland
				Tanzania
				Uganda
				Zambia
				Zimbabwe

[19] This classification, rather than individual countries, was used by at least one development agency.